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ABSTRACT

Noting that interaction between patients and health care providers is a critical factor in the delivery of medical care, this paper argues that an interpersonal perspective can and should provide the paradigm for the study of medical communication. It suggests that the relationship between the sociocultural context in health care and communication can be described in terms of four interrelated levels of context--cultural, socioinstitutional, functional, and situational. The discussion of these interrelated levels of contexts indicates that health care communication research should proceed in four directions: (1) determining how the socialization process in medicine influences individual beliefs about the nature, function, and value of communication; (2) providing an understanding of how the role systems in health care facilitate and constrain communication competence by orienting individuals toward certain modes of interpersonal behavior; (3) explicating the functions by which language has evolved in the health care arena through an examination of the goals, barriers, and strategies within the regulative, interpersonal, identity, and instructional contexts; and (4) focusing on how the social ecology of particular health care situations, the situated beliefs of social actors, and the sense of social structure that emerges in interaction together influence interpersonal behavior. (Author/RL)

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Interpersonal Competence and Communication in the Delivery of Medical Care
Directions for Research: A Constructivist Perspective

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The medical communication literature is diverse and scattered on a number of disciplinary fronts which make synthesis difficult. Although there is a significant body of health communication research, the primary contributions have come from medical sociology and psychiatry, which tend to investigate questions which are tangential to the fundamental concerns of our discipline. Despite the importance of communication in the delivery of medical care, our field has tended to remain on the sidelines and, as of yet, has had little systematic impact on medical practice.

A number of factors have tended to impede research and prevented richer, more fruitful conceptualizations of how communication functions in the delivery of medical care. The lack of a concentrated effort in the health care arena accounts in part for our fields lack of visibility. To do productive research in health care requires an understanding of the social world of medicine, as well as the lines of convergence between problem-oriented and theoretically-oriented research. Few have been willing to test the utility of our conceptual frameworks in applied research focused upon communication problems peculiar to health care. Consequently, there has been a tendency to conceptualize communication processes from an inadequate perspective and level, and a relative lack of theoretical exemplars for guiding specific lines of research. This study suggests that one potential exemplar to guide future research lies in the area of interpersonal competence.

Despite the centrality of the competence construct in interpersonal inquiry, a theory of communicative competence has remained elusive. In 1969 Goslin suggested that a central problem in developing a theory of communication was the difficult problem of integrating psychological, social and anthropological positions. Much the same can be said about the current state of theorizing about

interpersonal competence (Kelly, Chase, and Wieman, 1979). Even a cursory review of literature reveals that communication competence has been approached from a number of theoretical starting points (Weinstein, 1969; Hymes, 1971; Borchner and Kelly, 1974; Wiemann, 1977). Generally, positions such as these point to the cognitive and behavioral competencies which facilitate an individual's ability to adapt to the demands of the environment.

In studying interpersonal competence in health care, one should adopt theoretical perspectives which are consistent with evolving approaches to the delivery of medical care, which provide a means of tapping individual differences in the adaptive capabilities of caregivers and patients, and which provide an integrated account of the cognitive, behavioral, and socio-cultural resources which influence social adaptation. Medical science has begun to escape the confines of physiological reductionism by recognizing viewpoints which encourage a more wholistic view of the science of medicine. These viewpoints focus increasing attention on how health and illness are experienced by each individual. A collection of essays entitled Toward a Man Centered Medical Science points to the limitations of conventional scientific methods in biology and medicine (Schaefer, Hensel, and Brady, 1977). It is argued that only when a model uses as its starting point the autonomous individual will there be the possibility of a truly "man-centered" medical science. Positions which attempt to illumine the process of communication in health care need to recognize the active way in which persons organize and structure their environment, and the interface between the physiological and psycho-social factors which influence illness behavior.

A perspective on interpersonal competence should also provide a means of tapping individual differences in the adaptive capabilities of patients and health care providers. Schaefer (1977) suggests that an approach to medical

science which recognizes the importance of the individual will require a more comprehensive knowledge of individual differences in physiological functions, and their interrelationship with the organism and with the environment(xiii-xxii). Just as medical science is increasingly recognizing individual variability, communication researchers need to focus on how systematic differences in the control over the resources of communication influence interpersonal behavior. Finally a competence based approach should provide an integrated account of the interpretive, behavioral, and cultural factors which influence the process of adaptation.

The cognitive domain points to the interpretive schemes and attributional inference processes involved in social perception. The social cognitive competencies underlying a persons ability to understand the others perspective is a developmental achievement which is subject to individual differences (Delia and B. O'Keefe, 1979). Therefore, interpersonal competence depends in part on a persons ability to cognitively assess the beliefs and intentions of the other, the demands of the situation, and others probable response to various courses of action. In order to use communication as a strategic resource caregivers must first attempt to determine the patients perspective on the situations, and the way in which beliefs and intentions are likely to influence individual thought and action.

Communication adaptation depends not only on social cognitive abilities, but also on the actualization of communicative resources in the behavioral domain. Communication behavior can be functionally controlled at the nonverbal, linguistic, tactical-strategic, and socio-cultural levels. Reflective control over the resources of communication better enables one to influence anothers beliefs and perceptions, adapt messages to the demands of different listeners, and can facilitate the accomplishment of interpersonal objectives.

The cultural domain accounts for the impact of acculturation on communication. In the process of socialization within a particular group or culture individuals acquire generative systems of meaning and interpretation which organize and influence interaction. Cultural knowledge, general interpretive principles, (Cicourel, 1974; Grice 1975), and shared organizing schemes provide resources which facilitate the coordination of behavior. The components of these interpretive practices are the rules, ritualized routines, and socially constructed premises governing patterns of interaction which allow individuals to substantiate cultural frames of reference and engage in a social process (see B. O'Keefe and Delia, in press).

It is at the intersection of these three domains where our most productive insights about the nature of interpersonal competence are likely to be gained. Given the complexity of the competence construct, it is unlikely that an adequate explanation will emerge from a narrow theoretical viewpoint. The constructivist perspective which is attempting to weave together diverse perspectives may provide our best change for understanding interpersonal competence and communication in the delivery of medical care (see Clark and Delia, 1979; Applegate and Delia, 1980; and B. O'Keefe and Delia, in press).

In explaining the relationship between the cultural context of health care and social cognitive and behavioral performance, it may be useful to link specific contextual factors with developments in the interpersonal sphere. Rommetveit (1973) has argued persuasively that any communication transaction is indeed influenced by the institutional and situational premises embedded in, and which flow from the context of interaction (68-69). This paper articulates a problematic set of questions and issues for guiding competence research, which centers particular attention on how socio-cultural constraints on interaction are likely to influence communication in the delivery of medical care. The relationship between

culture and communication is described in terms of four interrelated levels of context: cultural; socio-institutional; functional; and situational.

CULTURAL CONTEXT

The cultural context embraces the taken for granted knowledge and shared understandings which organize and influence the general patterns of group life within the social world of medicine; it provides the broad overall boundaries which encompass the other levels of context. Research could be directed toward understanding how general socio-cultural and demographic antecedents influence interpersonal behavior (Salloway, 1976). For example, there has been little research geared toward examining how the education level of nurses influences social cognitive and communicative development. Given the diverse levels of educational attainment which characterize the nursing profession, the type and duration of training may account in part for differences in interpersonal competence. A number of studies have also suggested social class differences in listener-adapted communication (Alvy, 1973); Ponzer and Salz, 1974; and Cook-Gomperz, 1973).

Socio-cultural antecedents can provide a baseline for comparative analysis, but do not furnish much insight into the specific factors which account for the regularity and variability in communication functioning (see Schatzman and Strauss, 1975). This points to the utility of incorporating more refined analysis of possible cultural influences into studies of communication behavior. Although significant attention has been directed toward understanding the acculturation process in the health care professions (Clausen, 1967; Levinson, 1967; Menke, 1969, Eichna, 1980), no one has systematically examined how socialization shapes practitioners communication relevant perceptions and behaviors. A more heuristic starting point for understanding how tacit beliefs acquired in socialization

influence communication may be to study the implicit communication theories which provide the assumptive ground on which caregivers and patients beliefs about the nature of communication are based.

The idea of an implicit communication theory refers to the system of intersubjectivity which guides the production and interpretation of speech within a community of people engaged in significant discourse. The central questions to be answered in this regard are the following. How do health practitioners differentially view the culturally given and contextually negotiated functions of communication in the delivery of medical care? What do caregivers view as the important obstacles constraining the accomplishment of communication relevant goals and objectives? What do health care providers view as a competent way of adapting behavior strategically in order to fulfill these functions? The systematic collection of ethnomedical data should reveal more clearly the dimensions caregivers and patients use in making judgements about communication, and how these expectations influence behavioral performance in the health care setting.

SOCIO-INSTITUTIONAL CONTEXT

This level accounts for how the value structure within institutionalized role systems organize relationships, shape role identities, and defines the meaning of communicative actions.

Many theories and models have attempted to characterize the structure of role relationships in health care (Parsons, 1951; Szasz and Hollender, 1956; Friedson, 1961, 1970, 1975). Although these frameworks have contributed important insights about the organization and structure of role relationships, they have furnished precious little understandings of underlying communication processes. Research needs to provide a more precise description of the relationship between role systems in health care and the social cognitive and communicative

competence. Descriptive ethnographies of communication may provide useful knowledge about the different types of health related relationships, and the different ordering assumptions which nurses, patients, and physicians use to define and organize their social relationships.

Within health care there are many categories of relationships which are likely to differ in duration and intensity, and develop different sets of relational rules, and different interactional histories (Delia, 1980). The work on intimate relationships and friendship formation, much of which is based on the similarity attraction hypothesis and the assumption that relationships develop toward greater intimacy does not lend itself well to explaining relationships in health care. Generally, persons are not motivated to enter health related relationships by cost-reward considerations, or in search of the mutual exchange of social support. Patient's relationships with the nurse and physician are likely to follow different relational trajectories and vary according to the clinical situation. As chronic and degenerative diseases have become pervasive health care problems, the dynamics of the traditional nurse-patient relationship has been modified to a significant extent (Reeder, 1972). As physicians have increasingly less personal contact with patients, the communication between patients and members of the health care team take on greater significance (Bloom and Wilson, 1979). The communicative demands of these different types of relationships have been inadequately studied. It is likely that the ability to establish functional relationships with patients, and other providers will be influenced by the extent to which practitioners recognize the way in which the relational contact which emerges in interaction is facilitated and constrained by various institutional constraints.

In order to understand how various role systems influence communication one needs to move away from viewing interaction as a culturally determined enactment

between occupants of social roles, or as seeing roles as recipes for behavior. Instead, understanding communication as a emergent process of interactional coordination and negotiation, focuses attention not only on the socio-cultural forces which act on the individual, but also on what caregivers and patients bring to the encounter, and the way in which context relevant beliefs and intentions channel behavior (Berkanovic, 1972). It is important to understand the ordering principles practitioners use to create and negotiate relational contracts, because of the influence these relationships exert on patient expectations and behavior. We need to know more about what physicians, nurses, and patients think about the nature of their relationships (Larson and Rootman, 1976). Studies should be designed to uncover the implicit assumptions which guide relationships on particular trajectories, focus on how the relational messages embedded within the content of talk shape the nature of the caregiver-patient encounter, and consider how participants interactional history influences communication behavior.

Research might be profitably aimed at studying relationships developmentally in order to identify the stages which relationships pass through, and the interactional dynamics which characterize each behavioral phase. Initial stages of provider-patient relationships are often characterized by a high degree of uncertainty, and these initial interactions are likely to significantly influence relationship development.

The role systems within health care, are likely to exert a significant influence on interpersonal behavior. The work of Applegate and Delia (1980) provides a conceptual framework for explaining how the role system influences communicative action. Reformulating the work of Bernstein (1974), these authors argue that cultural symbol systems orient individuals toward certain modes of interpersonal behavior (position-centered and person-centered speech).

The difference between these two styles is reflected in the degree to which a persons communication is oriented toward individual differences or is grounded in the generalized rule and role structure operating in a particular social group. Position centered communication affirms the implicit knowledge shared by members of a common social nexus. A normatively governed role structure defines appropriate modes of action, and joint conduct is possible because of shared assumptions governing social life. This is in contrast to person-centered communication which is characterized by the ability to differentiate ones own perspective, and that of others, from the dominant role or cultural orientation, in order to construct a message which is decontextualized and adapted to the nature and demands of the situation.

The position-person centered distinction should prove useful in understanding how role systems in health care influence interpersonal behavior. Future research might profitably address the following questions: Do person-centered codes enhance developmental stratification—the ability to adapt communication to the nature and demands of the situation? To what extent do position and person centered communicators exhibit stable individual differences in their strategic communication behavior? To what extent is the competent communicator able to flexibly shift from a person-centered to a position-centered orientation depending on the demands of the situation?

FUNCTIONAL CONTEXT

This level accounts for the way in which the communicative orientation characteristic of a particular culture is realized through interactional encounters within four functional contexts: interpersonal; regulative; instructional; and identity (see Halliday, 1973). Context is used here as a means of assessing the socio-cultural constraints on the general functions of communication within the

health care arena. Following the lead of Clark and Delia (1979) it may be useful to identify the communication relevant goals central to the delivery of medical care, the individual beliefs and situational constraints which inhibit accomplishment of these objectives, and the strategies employed by caregivers to accomplish interpersonal tasks. We clearly need to know more about how the predominant cultural orientation penetrates these socialization contexts and the functional implications for patient-caregiver interaction.

Regulative Context. The focus of interaction in this context is on the way in which communication is used to control the environment and regulate individual behavior. Caregivers can use communication to influence patients health related beliefs in order to secure compliance and adherence with the medical regimen (Kasl, 1975; Rosenberg, 1976; Becker, 1979). Compliance is a particularly important problem for providers and remains somewhat of a paradox in the delivery of medical care. Despite dramatic advances in treatment and diagnosis a significant percentage of patients do not comply with medical directions (Stone, 1979). There has been substantial research on the psycho-social, and cultural variables associated with compliance and noncompliance (Haynes, 1976, Haynes, Taylor, and Sackett, 1979; Dunbar, 1980). The search for correlates of compliance and noncompliance may provide information useful in anticipating patient behavior, and explaining the obstacles or barriers to compliance. However, precious little systematic attention has been devoted to the ways in which caregivers adapt their communication in order to accomplish regulative tasks, and how the compliance gaining process is managed by caregivers and patients in ongoing interaction (Hulka, Cassel, Kupper, and Burdette, 1976; Komaroff, 1976; Svarstad, 1974, 1976).

In the regulative context research needs to proceed in at least two central directions: 1) accounting for how patient beliefs and situational factors are

likely to influence strategic message formulation and patient responses to alternative strategies; and 2) explaining the ways in which caregivers anticipate the outcomes of alternative compliance gaining messages, and adapt their behavior strategically in attempts to influence patient behavior. It may be that a competent communicator possesses a more expansive strategic repertoire, a broader base on which to make predictions, i.e., relying more on motivational and dispositional qualities in addition to cultural knowledge, and is thus better able to adapt communication to the demands of different patients and situations. Two lines of investigation in our field may provide useful points of departure for understanding the relationship between communication and compliance (Clark and Delia, 1979; and Jackson and Jacobs, 1980).

An evolving line of research represented by the work of Clark and Delia (1979) and Clark (1979) may prove useful in discovering effective ways for caregivers to present ideas to patients for the purpose of securing compliance and accomplishing other communication relevant objectives. A functional approach to the study of language presupposes that embedded within any interactional episode are simultaneously multiple communicative goals. Although the dominant objective in a situation may be compliance, issues relevant to patient identity and interpersonal relationships are likely to influence strategic message formulation. For example, in attempting to convince a patient of the necessity of a surgical procedure, an identity issue such as patient beliefs about alteration of body image, and relational issues such as potential impact on the family structure may interfere with goal attainment. In securing a belief or action in response to this problematic circumstance caregivers would have to provide general lines of argument for altering these potential obstacles to patient compliance. The competent communicator may be better able to recognize both the dominant and subsidiary objectives within a particular encounter and adapt

communication accordingly. Jackson and Jacobs (1980) are attempting to generate an explanation of language usage in social settings by focusing on the structure of conversation as it relates to the general functions of communication. This discourse analytic approach could provide a richer understanding of the strategies used by caregivers within a particular situation, and the lines of action employed by patients in response to compliance gaining requests (see Scott and Lyman, 1968). It may also provide a useful lens for viewing the way in which caregivers differentially alter their strategies as interaction unfolds in a particular communication event. For example, to what extent are interactional outcomes influenced by a caregivers ability to sustain a highly adaptive person centered mode of communication throughout a specific interaction.

Interpersonal Context. The focus of interaction in this context is on the way in which communication is used to establish, sustain, and alter interpersonal relationships. In the helping professions relationships can facilitate the accomplishment of both instrumental and affective goals. Instrumentally, the relationship provides the practitioner with a vehicle for securing cooperation and compliance (referent power), (Rodin and Janis, 1979). Affectively, the caregiver-patient relationship provides a resource for dealing with the psychosocial and emotional dimensions of illness. Despite the importance attributed to relationships in health care, inadequate attention has been devoted to examining the way in which providers and patients use communication to accept, reject, or modify the relational contract.

The constraints on communication in the interpersonal context are often a function of differences in power, status, and control. Social distance is likely to be an important constraining factor in some types of relationships, particularly the patient-physician relationship (Skipper and Leonard, 1965). Inability to reach a consensus on the issue of control is likely to constrain relational

development. For example, because of traditional role expectations some patients may respond poorly to women in positions of authority. With the increasing commitment to wholistic health care and a growing number of patients who are not satisfied with their interactions with health care providers, increasing attention needs to be directed toward examining what constitutes the appropriate role of communication in relationships where power, status, and knowledge are unequally shared.

A relationship is functional to the extent to which it is appropriate to the demands of the situation and serves the needs of the participants involved. Research should analyze situations from both the patients and providers perspective in order to uncover potential obstacles or barriers to relational development. Clearly we need to know more about the factors which constrain the process by which individuals coordinate lines of action in pursuit of mutually satisfying relationships.

The strategies and routines used to establish and maintain functional caregiver-patient relationships also merits consideration. Nursing in particular stresses the importance of empathy in dealing with the affective dimension of the patient-nurse relationship. However, the burden of the psycho-therapeutic perspective hangs heavy on the shoulders of the nursing profession. The nursing "tool box" is curiously empty when discussing the specific processes and strategies involved in understanding another's feeling state, or in using communication as a resource to deal with hurt or damaged feelings.

Patient response to compliance gaining messages are likely to be contingent upon perceptions of the nature of the relationship that exists with caregivers. Research needs to be directed at better understanding not only how role identities and patterns of relationships are worked out in interaction, but also on the strategies caregivers use to sustain relationships, and how patients perception

of the relationship influences health care outcomes. For example, caregivers are likely to differ in the extent to which they recognize the need to maintain a positive relationship with patients, and the way in which relational power can be used to facilitate goal accomplishment.

Instructional Context. The focus of interaction in this context is on the communication of information and knowledge necessary for adapting to the demands of the health care system (Waltzkin and Stoekle, 1972). In the instructional context communication is used by patients and providers to acquire, control, and transmit the information necessary for health care decision-making, education, and diagnosis. Communication is used by practitioners primarily to secure information for diagnosis, explain mode of treatment, offer medical recommendations, facilitate the aims of health promotion, and to meet the educational needs of patients and their families (Squyres, 1980).

Patients use information primarily to gain knowledge in order to facilitate adaptation to the illness role, and to construct explanations which can provide a legitimate basis for active health care participation (Roter, 1977). However, the social distribution of knowledge in the health care field is highly uneven. The person who enters the illness role often knows very little about the nature of disease and illness, or the delivery of medical care. Therefore, information is also used by caregivers, particularly physicians and nurses as a means of social control (McIntosh, 1974).

The barriers to information processing in health care have been fairly well documented. Functional and clinical uncertainty, use of technical language and medical jargon, and the tendency to underestimate patients capacity to understand and desire to know are a few of the factors associated with practitioner behavior which contributes to the distortion and control of information (Pratt, Seligman, and Reader, 1958; Davis, 1960; Francis, Korsch and Morris, 1969; McIntosh, 1974; McKinlay, 1975).

Various psychological barriers to receiving and processing information, inability to retain or recall medical directions, and tendency to take a passive role are some of the factors relevant to patient behavior which constrain the communication of information (Ley and Spelman, 1967; Korsch, Gozzi, and Francis, 1968; Golden and Johnson, 1970). Boreham and Gibson (1978) suggest that patients tend to express a strong desire for information but ask few questions because of general cultural constraints on communication and the "broader shared conception of what constitutes appropriate behavior in the context of medical consultation" (p. 414).

At present more is known about the obstacles and barriers to information processing in health care than how providers adapt their behavior strategically in pursuit of instructional goals. If information is one of the keys to functional adaptation, then we need to know more about the information processing behavior of caregivers and patients.

Since the diagnostic interview is often the only sustained contact between caregivers and patients, particularly physicians, research needs to continue to center on this important communication encounter (see Moser, 1975; Stimson and Webb, 1975; Byrne and Long, 1978; and Carrol and Monroe, 1980). However, research on medical interviewing should be conducted within a more general theoretical framework, in order that we can make more synthetic statements about the nature of the communication process (Rubin, 1979).

Identity Contest. The focus of interaction in this context is on the way in which communication is used in the presentation of self and in the control and management of identities in situated interactions (Goffman, 1959; Turner, 1958; Goffman, 1969; Blumstein, 1973). Communication provides practitioners with a vehicle for helping patients sustain a valid identity in the process of coping with the stress of the illness role. There is perhaps no other interactional

arena where the legitimation of individual identity and the ability to understand the relationship between self and other takes on greater significance than it does in the delivery of medical care. Adaptation to illness is perhaps one of the most difficult challenges a person must confront and the potential obstacles to identity maintenance are widespread. Depression, loss of normal role obligations, changes in body image, goal orientation, and patterns of social interaction all can wage a tremendous assault on patient self-concept.

The accomplishment of instrumental and relational objectives is often contingent upon caregivers ability to deal with issues relevant to patient identity. For example, the negative self image of a patient recovering from a stroke may directly interfere with the process of rehabilitation. Although identity management in interaction generally operates at an implicit level, the ability to create an identity for another (altercasting) congruent with ones own objectives would appear to be an important skill in patient care. Positive altercasting (face support) in which caregivers are able to provide patients with a more positive set of beliefs about self is likely to influence ability to adapt to the demands of illness (Brewin and Shapiot, 1979).

In the identity context we need to turn our attention toward the processes and strategies involved in impression formation and identity management (Cissna and Sieberg, 1979). Research might profitably focus on how health care providers perceive the role identities of patients, and the extent to these impressions recognize individuality or conform to role bound expectations. It may also be useful to look at the extent to which caregivers impressions of patients, and ability to recognize barriers to identity maintenance influences the choice and formation of strategic messages. Caregivers whose perceptions of patients are influenced by the passive expectations associated with the traditional illness role (Segal, 1976) may be less able to create messages which casts patients into a

role which demands more active involvement in health care decision-making. Given the constraints on research in the health care setting, questions relevant to identity management are not easily answered, but are particularly important considering the importance of this functional domain to overall health care outcomes.

Identifying the functions of communication peculiar to the delivery of medical care, further clarifying the potential obstacles which constrain the accomplishment of communication objectives, and establishing taxonomies of strategies which work to fulfill these functions should provide a solid foundation on which to build future research. Eventually we need to know what particular style of communication, and what specific interactional strategies are most useful in accomplishing which specific goals in what types of situations with what types of patients. Not only is our discipline well equipped to deal with the problem of strategic communication, but also this area have received virtually no attention in the study of medical communication.

SITUATIONAL CONTEXT

This level points to the way in which communication is constrained by ecological and situational constraints within the health care system. Just as there is tremendous variability in patient response to illness, interaction is likely to be influenced by the way in which caregivers differentially perceive and act upon the situations they encounter in the health care system. W.I. Thomas's original statement, "if men define situations as real, they are real in their consequences," provides a starting point for building an implicit theory of situations in the health care-domain (see Ball, 1972; Perinbanayagam, 1974). We need to consider how cultural patterns of interpretation and behavior, the situated beliefs of social actors, and the sense of social structure created in

interaction swirl together to influence situational definition (McHugh, 1968).

There are certain social, spatial, and temporal aspects of situations which organize behavior within specific health care contexts. Research might profitably proceed by describing the interactional demands of various clinical settings and the socially constituted norms, and conventions, employed to coordinate communicative action. With increasing specialization in health care, it is important to recognize now the social ecology of particular settings imposes different communicative demands on participants. Whereas traditional caregiver-patient relationships function within a limited context of association, extended care settings such as oncology and nephrology nursing significantly alter the interactional demands on participants so situated. Certain clinical situations in health care are likely to require a high degree of communicative competence and social skill. At a general level the impact of the physical and spatial environment on the range and character of interaction in the delivery of medical care is definitely a subject for future investigation. The spatial ecology of many clinical settings is often organized in a way which fails to consider the relationship between environment and social behavior.

An implicit theory of situations must also account for the interpretive practices which participants use to organize social life. These shared interpretive patterns are the rules which regulate how social interaction is organized and controlled. Both the pragmatic routines which organize work and the social conventions which regulate interaction impose a situational definition on caregivers and patients. As Emerson (1970) suggest, "many situations where the dominant definition is occupational or technical have a secondary theme of sociality which must be explicitly acknowledge,," (p. 91). Research needs to center on how the norms embedded within situations influence the tacitly shared beliefs about the forms and functions which interaction serves. What limitations

do health professional see imposed on them by the demands of the situation? To what extent is a persons' definition of the situation shaped by interaction with other practitioners?

Situational research also needs to center on how the routines which get developed within situations influence patterns of social interaction. Routines are the joint strategies for handling and coping with the recurring demands of a situation. Just as going to the doctor for a history and physical follows a fairly conventional form, caregivers and patients in many clinical situations are likely to organize their behavior to demonstrate they are producing routine forms. Research designed to illumine how social routines and conventions facilitate and constrain communication in various health care situations is certainly warranted.

Situational Definitional Negotiation. Although cultural patterns and processes embedded within the social structure exert a significant influence on communication, interaction is a function of individual intention as well as social convention. In building an implicit theory of situation one needs to account for the "variability, range, and heterogeneity of situational definitions" (Ball, 1972, 69) as well as how a sense of social structure is created and preserved in and through communication with others. The definition of the situation is an ongoing accomplishment as participants join together to construct a "working consensus" which is used as a basis for constructing shared meaning. Suggesting that an individuals definition of the situation is a product of negotiation focuses attention on the beliefs and intentions of situated social actors, and their self-determined lines of action. It is likely that there is significant variability in the way in which caregivers perceive and use the rules and norms governing social conduct. However, we do not have a very reflective understanding of the way in which individual intentions and beliefs influence the process of situational

definition, nor the ways in which persons differentially exploit the interactional structure within a particular clinical setting.

In studying the impact of situation on perception and behavior, a factor which has received little attention is the patients perspective. One dimension of quality of care might be tapped by focusing on patients perceptions of the treatment situation (Hall and Pill, 1975; Hill, 1978). One might look at the extent to which patient perceptions are a function of the situational definition imposed by health care providers (see Caterinicchio, 1979). We know very little about how the extent to which adaptive response to illness is influenced by patients perceptions of the treatment situation. How do patients and staff differ in their perceptions of the interpersonal climate? Do these perceptions differ in situations where there is considerable person-oriented talk (see Delia, Clark, and Switzer, 1980)? To what extent is the interpersonal climate a function of a mutually shared definition of the situation?

Clark and Delia (1979) argue that a range of issues emerge in any interaction which form general constraints on behavior. These emergent constraints on interaction include such things as participants beliefs about identities, the rules governing relationships, and interactants communication relevant goals and objectives. A persons definition of these situationally emergent issues is likely to significantly influence interpersonal behavior.

In many clinical setting posing the question, "what constitutes quality of care" would probably engender a wide range of different responses. How a practitioner perceives the goals of health care may be a function of the skills and training brought to the situation, as well as the consensus which emerges as a result of interaction with other caregivers.

The identities which get worked out in interaction may also influence the communication behavior of both providers and patients. Identities carry with

them certain expectancies, and for example, patients defined as "hostile" or "passive" are likely to be treated in terms of the constraints imposed by that particular social definition.

Beliefs about how action is to be conducted within socially defined relationships are also subject to situational negotiation. To the extent that providers and patients cannot negotiate a relational contract which meets individual needs and is consistent with the goals of treatment the quality of patient care is likely to be adversely influenced. We definitely need to know more about how beliefs about identities and relationships influence patient and caregiver behavior within specific clinical settings.

It has been argued that building implicit theories of situations will require understanding how socio-cultural organizing schemes influence interaction in particular social locations, how caregivers and patients understand the nature of the situation, and how situational definitions emerge in ongoing interaction. Perhaps more importantly we will want to know how the nature of the situation facilitates and constrains communication competence. In addition to focusing on the interactional demands of particular clinical settings, we need to know whether practitioners possess the communicative competencies necessary to meet those demands, and the impact of the situation on actual performance. In this regard, research should proceed in three directions: identifying the goals of health care delivery in specific situations; determining how communication can be used as a resource to facilitate goal attainment; and focusing on the specific communicative skills required of situated interactants.

Finally, research needs to illumine the extent to which situational exigencies mediate the relationship between competence and performance. Is there a gap between providers communicative potential and actual performance due to the demands of the situation? Researchers in diverse fields have pointed to the

constraining influence of stress, emotional involvement and situational ambiguity on task and behavioral performance (Lewin, 1951; Mehrabian, 1968; and Rosenbach, Crockett, and Wapner, 1973). That many health professionals work in a psychologically demanding work environment is sufficiently obvious. However, little research has attempted to determine how various situational factors constrain the interpersonal capital a person can or is willing to invest in meeting the demands of the situation.

In this regard research should also probe the factors which impinge upon the psychological and emotional state of caregivers and the way in which they adapt their behavior in stressful situations. Factors such as helplessness (Seligman, 1975), role strain and role conflict, anger and alienation (Grant, 1980) degree of patient contact, and demand for cognitive involvement are likely to influence interpersonal competence. Some of the questions to be answered in this regard are the following: What kinds of communicative competencies facilitate adaptive functioning in high stress situations? When situations are defined as stressful, do caregivers see stress as primarily a function of internal or external factors? To what extent do the psychological demands of various clinical settings foster cognitive and communicative regression? (see Pettegrew, Thomas, Costello, et al., 1980).

The interactional demands of the health care context are complex and researchers using both quantitative and observational accounts have the best chance of understanding communication behavior in the delivery of medical care. At a general level research projects should be designed which are both problem-oriented and theoretically oriented, and which address the difficult problem of linking communication competencies with general and specific health care outcomes. A persistent problem in medical communication research has been the failure to ground research in specific theories of interactions. The utility of the

constructivist approach in unraveling the ways in which social cognitive and communicative competencies interrelate with the social world of medicine appears promising. Testing the social utility of our substantive theoretical positions with the goal of improving the quality of patient care may enable us to make a pragmatic and enduring contribution to socio-medical practice.

REFERENCES

- Alvy, K.T. The development of listener-adapted communication in grade school children from different social class backgrounds. Genetic Psychology Monographs, 1974, 10, 33-104.
- Applegate, J., and Delia, J. Person centered speech, psychological development, and the contexts of language usage. In R. St. Clair and H. Giles (Eds.), The social and psychological contexts of language. Hillsdale, N.J.: Erlbaum, 1980.
- Ball, D. The definition of the situation: Some theoretical and methodological consequences of taking W.I. Thomas seriously. Journal for the Theory of Social Behavior, 1972, 2, 61-82.
- Becker, M. Understanding patient compliance: The contribution of attitudes and other psychosocial factors. In S. Cohen (Ed.), New directions in patient compliance. Lexington, Mass., 1979, 1-31.
- Berger, C., and Calabrese, R. Some explorations in initial interaction and beyond: Toward a developmental theory of interpersonal communication. Human Communication Research, 1975, 1, 99-112.
- Berkanovic, E. Lay conceptions of the sick role. Social Forces, 1972, 51, 53-64.
- Bernstein, B. Class, codes and control: Theoretical studies towards a sociology of language (Rev. ed.). New York: Schocken Books, 1974.
- Bloom, S., and Wilson, R. Patient-practitioner relationships. In H. Freeman, S. Levine, and L. Reeder (Eds.), Handbook of medical sociology. Englewood Cliffs, N.J.: Prentice Hall, 1979.

- Blumstein, P. Audience, Machiavellianism, and tactics of identity bargaining. Sociological Quarterly, 1973, 36, 346-365.
- Bochner, A., and Kelly, C. Interpersonal competence: Rationale, philosophy, and implementation of a conceptual framework. The Speech Teacher, 1974, 23, 279-301.
- Boreham, P., and Gibson, D. The informative process in private medical consultations: A preliminary investigation. Social Science and Medicine, 1978, 12, 409-416.
- Brewin, C., and Shaplot, D. Beliefs about the self and their importance for motivation in rehabilitation. In D.J. Osborne, M.M. Gruneberg, and J.R. Eiser (Eds.), Research in Psychology and Medicine, Vol. II. New York: Academic Press, 1979, 437-443.
- Byrne, P., and Long, B. Doctors talking to patients: A study of the verbal behavior of general practitioners consulting in their surgeries. London: Her Majesty Stationery Office, 1978.
- Carroll, J., and Monroe, J. Teaching Clinical Interviewing in the health professions: A review of empirical research. Evaluation and the Health Professions, 3, 1980, 21-45.
- Caterinicchio, R. Testing plausible path models of interpersonal trust in patient-physician treatment relationships. Social Science and Medicine, 1979, 13, 81-89.
- Cicourel, A.V. Cognitive sociology. New York: Free Press, 1974.
- Cissna, K., and Sieburg, E. Interactional foundations of interpersonal confirmation. Paper presented to the International Communication Association and Speech Communication Association Postdoctoral Conference, "Human Communication From the Interactional View," Asilomar, CA., February 1979, 15-18.

- Clark, R.A. The impact of self interest and desire for liking on selection of communicative strategies. Communication Monographs, 1979, 46, 257-273.
- Clark, R.A., and Delia, J.G. Topol and rhetorical competence. Quarterly Journal of Speech, 1979, 65, 187-206.
- Clausen, L. Organism and socialization. Journal of Health and Social Behavior, 1967, 8, 243-252.
- Cook-Gumperz, J. Social control and socialization. London: Routledge, Kegan, and Paul, 1973.
- Daniels, M. Affect and its control in the medical intern. In T. Millon (Ed.), Medical behavioral science. Philadelphia: W.B. Saunders, 1975, 440-445.
- Davis, F. Uncertainty in medical prognosis: Clinical and functional. American Journal of Sociology, 1960, 66, 41-47.
- Davis, M. Variations in patients' compliance with doctors' advice. An empirical analysis of patterns of communication. American Journal of Public Health, 1968, 58, 274-288.
- Delia, J.G. Some tentative thoughts concerning interpersonal relationships and their development. Western Journal of Speech Communication, 1980, 44, 97-103.
- Delia, J.G., and O'Keefe, B.J. Constructivism: The development of communication in children. In E. Wartella (Ed.), Children Communicating. Beverly Hills, CA.: Sage, 1979.
- Delia, J.G., Clark, R.A., and Switzer, D.E. The content of informal conversations as a function of interactants interpersonal cognitive complexity. Communication Monographs, 1979, 46, 274-281.
- Delia, J., O'Keefe, B., and O'Keefe, D. The constructivist approach to communication in F. Dance. Comparative Human Communication Theory. New York: Harper and Row, forthcoming.

- Dunbar, J. Adherence to medical advice. International Journal of Mental Health, 1980, 9, 70-80.
- Eichna, L.W. Medical school education 1975-1979. The New England Journal of Medicine, 1980, 303, 727-734.
- Emerson, J. Behavior in private places: Sustaining definitions of reality in gynecological examinations. In H. Dreitzel (Ed.), Recent Sociology, No. 2, New York: Macmillan, 1970, 73-97.
- Francis, V., Korsch, B., and Morris, M. Gaps in doctor-patient communication: Patients' response to medical advice. New England Journal of Medicine, 1969, 280, 535-540.
- Francis, V., Korsch, B., and Morris, M. Gaps in doctor-patient communication II. New England Journal of Medicine, 1969, 280, 535-540.
- Freidson, E. Patients' view of medical practice. New York: Russell Sage, 1961.
- Freidson, E. Profession of medicine: A study in the sociology of applied knowledge. New York: Dodd-Mead, 1970.
- Freidson, E. Doctoring together: A study of professional social control. New York: Elsevier, 1975.
- Goffman, E. The presentation of self in everyday life. Garden City, N.Y.: Doubleday, 1959.
- Goffman, E. Strategic interaction. Philadelphia: University of Pennsylvania Press, 1969.
- Golden, J., and Johnson, G. Problems of distortion in doctor-patient communication. Psychiatry in Medicine, 1970, 1, 127-149.
- Goslin, D. (Ed.), Handbook of socialization theory and research. Chicago: Rand McNally, 1969.

- Grant, B. Anger and alienation: Occupational communication hazards for nurses and other health care workers. Paper presented at the annual meeting of the International Communication Association, Acapulco, Mexico, May 1980.
- Grice, H.P. Logic and Conversation. In P. Cole and J.L. Morgan (Eds.), Syntax and Semantics, Vol. 3: Speech Acts. New York: Academic Press, 1975.
- Hall, D., and Pill, R. Social climate and ward atmosphere. Social Science and Medicine, 1975, 9, 529-534.
- Halliday, M.A.K. Explorations in the functions of language. London: Edward Arnold, 1973.
- Haynes, R.B. A critical review of the determinants of patient compliance with therapeutic regimens. In D.L. Sackett and R.B. Haynes (Eds.), Compliance With Therapeutic Regimens. Baltimore: Johns Hopkins University Press, 1976.
- Haynes, R.B., Taylor, D.W., and Sackett, D.L. (Eds.), Compliance in Health Care. Baltimore: Johns Hopkins University Press, 1979.
- Hill, C. Differential perceptions of the rehabilitation process: A comparison of client and personnel incongruity in two categories of chronic illness. Social Science and Medicine, 1978, 12, 57-63.
- Hulka, B., Cassel, J., Kupper, L., and Burdette, J. Communication, compliance and concordance between physicians and patients with perscribed medications. American Journal of Public Health, 1976, 66, 847-53.
- Hymes, D. Competence and performance in linguistic theory: In R. Huxley and E. Ingram (Eds.), Language acquisition: Models and methods. New York: Academic Press, 1971, 3-28.

- Hymes, D. Foundations of sociolinguistics: An ethnographic approach.
Philadelphia: University of Pennsylvania Press, 1979.
- Jackson, S., and Jacobs, S. Structure of conversational argument: Pragmatic bases for the enthymeme. Quarterly Journal of Speech, 1980, 66, 251-265.
- Kasl, S.V. Issues in patient adherence to health care regimens. Journal of Human Stress, 1975, 1, 5-17.
- Kelly, C., Chase L., and Wieman, J. Interpersonal competence: conceptualization, measurement and future considerations. Paper presented at the annual meeting of the Speech Communication Association, San Antonio, Texas, 1979.
- Komaroff, A. The practitioner and the compliant patient. American Journal of Public Health, 1976, 66, 833-835.
- Korsch, B., Gozzi, E., and Francis, V. Gaps in doctor-patient communication. Pediatrics, 1968, 42, 855-71.
- Larson, D., and Rootman, I. Physician role performance and patient satisfaction. Social Science and Medicine, 1976, 10, 29-32.
- Levinson, D. Medical education and the theory of adult socialization. Journal of Health and Social Behavior, 1967, 8, 253-265.
- Lewin, K. Field theory in social sciences: Selected theoretical papers.
D. Cartwright (Ed.). New York: Harper and Row, 1951.
- Ley, P., and Spelman, M. Communicating with the patient. St. Louis, Missouri: Warren H. Green, 1967.
- McHugh, P. Defining the situation. Indianapolis: Bobbs and Merrill, 1968.
- Mehrabian, A. An analysis of personality theories. Englewood Cliffs, N.J.: Prentice Hall, 1968.

- McIntosh, J. Processes of communication, information seeking and control associated with cancer: A selective review of the literature. Social Science and Medicine, 1974, 8, 167-187.
- McKinlay, J. Who is really ignorant: Physician or patient. Journal of Health and Social Behavior, 1975, 16, 3-11.
- Menke, W. Professional values in medical practice. New England Journal of Medicine, 1969, 280, 930-936.
- Moser, R. The first five minutes. JAMA, 1975, 231, 1169-1170.
- O'Keefe, B.J., and Delia, J.G. Psychological and interactional dimensions of communicative development. In H. Giles, R. St. Clair, and M. Hewstone (Eds.), Language and the paradigms of social psychology. Hillsdale, N.J.: Erlbaum, in press.
- Perinbanayagam, R. The definition of the situation: An analysis of the ethnomethodological and dramaturgical view. Sociological Quarterly, 1974, 15, 521-541.
- Pettegrew, L., Thomas, R., Costello, D., Wolf, G., Lennox, Lynne, and Thomas, S., Job-related stress in a medical center organization: Management of communication issues. In D. Nimmo (Ed.), Communication Yearbook 4. New Brunswick, N.J.: Transaction Books, 1980.
- Ponzer, J., and Saltz, E. Social class, conditional communication, and egocentric speech. Developmental Psychology, 1974, 10, 764-771.
- Pratt, L., Seligmann, A., and Reader, G. Physicians' view on the level of medical information among patients. In E. Gartley Jaco (Ed.), Patients, Physicians and illness. Glencoe, Illinois: The Free Press, 1958, 222-229.
- Reeder, L. The patient client as a consumer: Some observations on the changing professional-client relationship. Journal of Health and Social Behavior, 1972, 13, 406-412.

- Rodin, J., and Janis, I. The social power of health care practitioners as agents of change. Journal of Social Issues, 1979, 35, 60-72.
- Rommetveit, R. On message structure. New York: Wiley, 1973.
- Rosenbach, D., Crockett, W., and Wapner, S. Developmental level, emotional involvement and the resolution of inconsistency in impression formation. Developmental Psychology, 1973, 8, 120-130.
- Rosenburg, S. Patient education--An educator's view. In D. Sackett., and R. Haynes (Eds.), Compliance with therapeutic regimes. Baltimore: John Hopkins University Press, 1976, 93-99.
- Roter, D. Patient participation in the patient-provider interaction. Health Education Monographs, 1977, 5, 281-306.
- Rubin, R.B. The effect of context on information seeking across the span of initial interactions. Communication Quarterly, 1979, 27, 13-20.
- Salloway, J.C. Medical care utilization among urban gypsies. Urban Anthropology, 1973, 2, 113-126.
- Schaefer, K., Hensel, H., and Brady, R. Toward a man-centered medical science: A new image of man in medicine. Vol. 1. New York: Futura, 1977.
- Schaefer, K. Introduction. In Schaeffer, K., Hensel, H., and Brady, R. Toward a man-centered medical science: A new image of man in medicine. Vol. 1. New York: Futura, 1977.
- Schatzman, L., and Strauss, A. Social class and modes of communication. In T. Millon (Ed.), Medical behavioral science. Philadelphia: W.B. Saunders, 1975, 402-411.
- Scott, M., and Lyman, S. Accounts. American Sociological Review, 1968, 33, 46-62.
- Segall, A. The sick role concept: Understanding illness behavior. Journal of Health and Social Behavior, 1976, vol. 17, 163-170.

Seligman, Martin E.P. Helplessness: On depression, development and death.

San Francisco: Freeman, 1975.

Skipper, J., Tagliacozzo, D., and Maoksch, H. Some possible consequences of limited communication between patients and hospital functionaries.

Journal of Health and Human Behavior, 1964, 5, 34-40.

Skipper, J., and Leonard, R. Social interaction and patient care.

Philadelphia: J.B. Lippincott, 1965.

Squyres, W. Patient education: An inquiry into the state of the art. Vol. 4.

New York: Springer Publishing Co., 1980.

Stimson, G., and Webb, B. Going to see the doctor: The consultation process in general practice. London: Routledge, Kegan, and Paul, 1975.

Stone, G. Patient compliance and the role of the expert. Journal of Social Issues, 1979, 1, 34-59.

Svarstad, B. The doctor-patient encounter: An observational study of communication and outcome. Unpublished doctoral dissertation, University of Wisconsin, Madison, 1974.

Svarstad, B. Physician-patient communication and patient conformity with medical advice. In D. Mechanic (Ed.), The growth of Bureaucratic medicine: An inquiry into the dynamics of patient behavior and the organization of medical care. New York: Wiley-Interscience, 1976, 220-238.

Szasz, T., and Hollender, M. A contribution to the philosophy of medicine: The basic models of the doctor-patient relationship. A.M.A. Archives of Internal Medicine, 1956, 97, 585-592.

Turner, R. The self-conception in social interaction. In C. Gordon, and K. Gergen (Eds.), The self in social interaction. Vol. 1: New York: Wiley, 1958, 93-106.

Waltzkin, H., and Stoeckle, J. The communication of information about illness: Clinical, sociological and methodological considerations. Advanced Psychosomatic Medicine, 1972, 8, 180-215.

Weinstein, E. The development of interpersonal competence. In Goslin, D. (Ed.), Handbook of socialization theory and research. Chicago: Rand McNally, 1969.

Wiemann, J.M. Explication and test of a model of communicative competence. Human Communication Research, 1977, 3, 195-213.